WORLD HEALTH ORGANIZATION

TOBACCO ALERT

JANUARY 1992

EDITORIAL

SMOKE-FREE OLYMPIC GAMES IN BARCELONA

It is the responsibility of the Organizing Committee of the Games of the XXV Olympiad to provide the best possible facilities and conditions of comfort during the Games. This includes providing a healthy environment for all participants.

The Barcelona '92 Olympic Games, following the trend set in Calgary and Seoul, have been declared smoke-free to protect the health of the athletes and to reinforce the association between sport and health. To this end COOB'92 (the official organizing committee) has created the Smoke-Free Games Programme.

The aims of this Programme are:

1. To protect athletes and other participants from tobacco smoke.

2. To provide members of the Olympic organization and volunteers with smoke-free workplaces.

3. To give the world the image of a healthy city and country.

In order to achieve these aims, an agreement has been signed between the Ministry of Health and Consumer Affairs, the Department of Health and Social Security of the Generalitat of Catalonia, the Barcelona City Council and COOB'92, with the cooperation of the World Health Organization. **This agreement recognizes the prejudicial effects of tobacco on athletes and the risk that smoking represents to health.**

The programme has its own logotype which combines an image related to health with the symbol of the Barcelona Olympic Games. Together with the usual international symbols, the logotype will help to signpost the smoke-free areas where special respect for the athletes is demanded in order to protect them from passive exposure to cigarette smoke. Cigarette advertising will also be prohibited as will the sale of cigarettes within the sports venues. Further activities are aimed at declaring the medical care premises in the villages and at the venues smoke-free areas and to prohibit smoking on transport provided for the Olympic family.

These activities will also mean that everybody who comes to Barcelona during the Games will find the city cleaner and more welcoming.

José I. Cuervo
Director
Olympic Family Services, COOB'92

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SOCIETY

CHINESE RURAL FARMERS' QUITTING PROJECT

Background

Eighty per cent of the Chinese population live in rural areas where, according to the 1984 National Prevalence Survey, two-thirds of the male population smoke. Smaller, more recent, surveys indicate that farmers' smoking has been rising at about 1% per annum, and prevalence could reach as high as 80% by the end of this century if health departments do not intervene. Although fewer women (7%) smoke, in some rural areas this figure too is increasing.

Most health education programmes to reduce smoking in China have hitherto been for the general public, and have been less accessible to farmers. Therefore, in 1990 the National Health Education Institute of China decided to design the most suitable cost-effective strategies for smoking cessation among Chinese farmers.

It was anticipated there would be considerable difficulties in such a programme, not the least of which was access to farmers in very remote areas. Also, some farmers – especially the older ones – are illiterate or semi-literate (the very group with whom the anti-smoking campaigns in developed countries have had the least success), thus written health education materials are of limited value. In addition, many farmers perceive smoking to be their only form of relaxation, especially those in remote areas where there are few forms of entertainment.

However, it was found that many farmers, once reached, were particularly appreciative of gaining health knowledge and were enthusiastic about participating in a pilot national programme.

This project is also a pilot in that it is testing a recently introduced systematic approach to health education in China, planning a smoking control campaign on a 6-point basis for the first time:

Data base: Establishing a data base to identify major problems, prioritizing problems identified and choosing a particular problem for a project:

- Objectives: Making practical objectives within a specified time framework.
- Strategy and operational plan.
- Policy support: Clarifying policy support, especially from the *"leaders"* and in this case the provincial and county authorities.

- Resources: Defining resources – financial, human and technical.
- Monitoring and evaluation.

Study population

The 1990-1993 project is being undertaken in ten different rural areas of 6 widely-spread provinces – Shanxi, Hebei, Fujian, Henan, Zhejiang and Heilongjiang. There are 5 000 participants aged between 15 to 60 years from each area, totalling 50 000 people divided into intervention and control groups.

Objectives

Behavioural objectives by the end of the 3-year project are:

- to reduce the smoking rate by 5%;
- for 85% of the intervention group to attempt to quit;
- for 95% of the population to observe smoke-free public places;
- for 99% of women farmers to abstain from smoking during pregnancy.

Educational objectives are for:

- 95% of the intervention group to be able to identify the major harmful consequences of smoking;
- an anti-smoking atmosphere to have been created;
- 95% of the intervention group to teach their children not to smoke;
- remaining smokers to refrain form offering cigarettes to their friends as well as asking permission from people around them before lighting up.

Forms of intervention

The Provincial Health Education Institutes have been mobilized to inform farmers in the intervention groups repeatedly of the harmfulness of smoking. The farmers are also receiving a variety of behavioural advice, with self-help support groups being established, children mobilized by the schools to encourage their parents to quit and, in some circumstances, acupuncture. Competitions for smoke-free households, and even smoke-free villages, are being held.

In addition, a promotional tour of the project villages in Shanxi Province was organized by the National Health Education Institute in October 1991. The high-powered delegation included a Vice Minister of Health, the Director of the Institute, Dr Chen Bing Zhong, the Project Director, Dr Zheng Baoyi and many senior officials from the Chinese Academy of Medical Sciences and the Chinese Academy of Preventive Medicine, as well as three *"foreign experts"*. A bus-load of the national press corps accompanied the entire visit. In addition, local dignitaries joined the group, swelling the numbers to over 200.

The serious and important side of this *"roadshow"* was to demonstrate senior national, provincial and also international endorsement, support and encouragement for the anti-smoking movement. After the first year, according to the local public health bureau, the number of smokers in six small Shanxi villages is down 6-8%. If this can be translated nationally, the opportunity to reduce tobacco-related mortality in the future is substantial.

Although reducing the enormity of 300 million smokers in China is a daunting task, this project has made a start at grass-roots level, illustrating the ancient Chinese proverb *"It is better to light a candle than to curse the darkness"*.

PUBLICATION

TOBACCO CONTROL: AN INTERNATIONAL JOURNAL

In the light of the enormous public health burden of tobacco-related disease, and the vast scientific literature and on-going research on tobacco and health, a broad-based scientific journal on tobacco and health was needed. (By contrast, at least 12 journals cover alcohol-related disorders.) In November 1989, Dr Ronald Davis, then Director of the US Office on Smoking and Health, proposed at a meeting of the WHO Technical Advisory Group (TAG) on Tobacco or Health that a scientific journal on tobacco and health be created. The TAG endorsed the concept, but raised questions and concerns about the sponsors, cost, and content of such a journal. The TAG asked Dr Davis to convene a meeting of interested individuals and organizations at the Seventh World Conference on Tobacco and Health in Perth, Australia, in April 1990.

At the Perth Conference, 25 international leaders in the tobacco or health field discussed this proposal. Specific recommendations related to the content of the journal were made, and Ms Pamela Taylor of the British Medical Association (BMA) indicated that the BMA might be interested in publishing such a journal, an idea that was greeted with enthusiasm. It was intended that the new journal would cover all the various aspects of the multi-faceted problems of tobacco use including the relationship between tobacco use and disease, smoking-attributable mortality, trends in tobacco use, smoking behaviour, economic costs and environmental impact of tobacco use, smoking cessation treatments, and tobacco control interventions (programmes and policies).

In September 1991, the BMA agreed to launch this new journal on tobacco control. The name of the new publication will be: **Tobacco Control: An International Journal.** The first issue is scheduled for publication in early March 1992, just before the Eighth World Conference on Tobacco or Health being held in Buenos Aires on 30 March-3 April 1992. An editorial and a call for papers formally announced the journal in the 28 September 1991 issue of the **British Medical Journal.**

The main aims of the new journal are to improve the worldwide dissemination of information on the medical, scientific, socio-economic and political aspects of tobacco use; to increase the accessibility and facilitate the retrieval of information on tobacco and health by bringing much of it to a central source; and to strengthen the global network of tobacco-and-health researchers and anti-tobacco advocates.

The name of the journal indicates its focus. Although occasional articles on the health effects of tobacco use will be published (e.g. impact on public health, health effects of passive smoking, and new areas such as smoking and leukaemia), the major emphasis will be on matters pertinent to the prevention and control of tobacco use. Besides peer-reviewed articles, the journal will include a news section, commentaries, editorials and book reviews, to allow dissemination of a diversity of information.

The subtitle of the journal's name indicates that the content will be international in scope. In fact, given the dearth of published research on tobacco for most developing countries, special efforts will be made to recruit manuscripts from such countries.

The editor is Dr Ronald M. Davis, who is now Chief Medical Officer of the Michigan Department of Public Health. The deputy editor is Dr Simon Chapman, a lecturer at the Department of Community Medicine, University of Sydney (Australia). Submissions and papers should be sent to: Ronald M. Davis, M.D., Editor: **Tobacco Control,** Michigan Department of Public Health, 3423 North Logan Street, P.O. Box 30195, Lansing, Michigan 48909, USA. Tel: (517) 335-8011, Fax: (517) 335-9476.

NEWS BRIEF

TO SMOKE OR TO WORK: WILL THAT BE THE CHOICE?

The days of smoking at the workplace do indeed seem numbered in the United States of America, where more and more companies are adopting anti-smoking measures. In four years, the number of employers who have banned smoking in the workplace has increased five-fold, according to a study recently published in Washington by the Bureau of National Affairs and the Society for Human Resource Management. Eighty-five per cent of the 833 companies that belong to this Society reported that they had taken anti-smoking measures, an increase of 54% in comparison with 1987. During the same period, the number of companies which banned smoking completely rose from 7% to 35%.

As for the reasons why such measures had been taken, 79% of the companies referred to the health and comfort of their employees, 59% said their employees had complained about tobacco smoke, and 36% were merely applying local laws.

According to the correspondent of the **Wall Street Journal** who reported this news, 85-90% of the companies that have smoking policies ban smoking in corridors and conference rooms. The banning of smoking in individual offices, staff rooms and cafeterias has doubled in four years and is applied in almost 60% of these companies.

READEX FICHE

SOCIETY

SMOKING BY YOUNG EUROPEANS BETWEEN THE AGES OF 11 AND 15 FROM INITIATION TO DEPENDENCE

A study was carried out in June-July 1990 for the first time within the European Community on young people's behaviour and attitudes with regard to smoking. Altogether 9 312 boys and girls between the ages of 11 and 15 were interviewed in the 12 Member States, without their parents. The 11-15-year age group was chosen so as to shed light on the period of life when people try smoking for the first time and begin to acquire their first smoking habits.

I. Tobacco consumption

The **initiation to smoking** is the first step towards dependence on tobacco. On the whole, between ages 11 and 15 slightly fewer girls than boys had smoked at least once: 24% of girls against 30% of boys. The proportion of young people who have tried smoking increases with age: 2% smoked their first cigarette at age 7 or earlier, while 13% had their first smoke at age 14.

Young people and smoking

	Boys	Girls	Both
Have already smoked at least once and:	30%	24%	27%
– smoke at least once a week	6%	5%	5%
– smoke less than once a week	3%	2%	5%
– no longer smoke at all	21%	17%	19%
Have never smoked	70%	76%	73%

The fact that someone has tried smoking once is only a very partial indicator of young people's **current tobacco consumption.** The number of young people who currently smoke is much lower than the number who have tried smoking at least once: of the 27% who have tried it, only 8% currently smoke; 19% no longer smoke at all. The main reason young people have stopped smoking is because *"it's bad for your health"*.

At ages 14 and 15, the number of regular smokers increases significantly. In the 12 EEC countries, on average 15% of 15-year-olds smoke at least once a week.

The amount smoked increases with age: smokers consume on average 4.2 cigarettes per day between the ages of 11 and 13, and 6.3 cigarettes at age 15. More boys than girls are heavy smokers (11 to 20 cigarettes per day).

II. Advertising

Advertising for cigarette brands is one of the elements of young Europeans' surroundings which affects their smoking behaviour.

Responsiveness to cigarette advertising, measured by the ability to name one or more cigarette brands whose advertising the respondent finds particularly attractive, is 23% for girls and 31% for boys. Girls' interest in cigarette advertisements increases gradually with age, while with boys there is a sharp increase around age 15.

It is clear that cigarette smoking and interest in cigarette advertising are linked; in the Community as a whole, 57% of those who smoke regularly are able to name a brand of cigarettes whose advertisements they like; this number drops to 45% for young people who do not smoke regularly and to 31% for those who have smoked but no longer do so. Only 23% of children who have never smoked are able to name a brand.

Responsiveness to advertising and smoking among boys and girls

	Smokers		Current non-smokers	Never smoked	All groups
	Regular	Occasional			
Boys					
Name brand	65	53	34	26	31
Do not name a brand	35	47	66	74	69
Total	100%	100%	100%	100%	100%
Girls					
Name a brand	48	33	28	21	23
Do not name a brand	52	67	72	79	77
Total	100%	100%	100%	100%	100%
Both sexes					
Name a brand	57	45	31	23	27
Do not name a brand	43	55	69	77	73
Total	100%	100%	100%	100%	100%

As we have seen, there is **a link between tobacco consumption and responsiveness to cigarette advertising.** Is there a relation between the brand smoked and the brand named? Young people are more likely to name the advertising of the brand they smoke or to smoke the brand whose advertising they name.

III. Views on tobacco

	Agree completely	Mostly agree	Mostly disagree	Disagree completely	No reply	Total
	%	%	%	%	%	%
Smoking is bad for your health	88	7	1	2	2	100
Once you start smoking you might not be able to stop	54	25	8	7	6	100
Smoking is expensive	67	19	4	3	7	100
Passive smoking is dangerous	65	21	4	4	6	100
Smoking soothes the nerves	5	13	12	56	14	100
Smoking helps you work	1	4	13	71	11	100
Smoking helps you stay slim	8	11	12	43	26	100
When you are with friends, it is hard to refuse an offer of a cigarette	11	16	15	49	9	100
Among friends, smoking creates a pleasant atmosphere	5	12	17	55	11	100

The first thing that must be noted is that most young Europeans have quite a negative view of smoking: 8% agree completely that "*smoking is bad for your health*". Yet only 54% of them agree completely that "*once you start smoking, you might not be able to stop*". There are also a large number who give no reply as to whether "*smoking helps you stay slim*" and "*smoking soothes the nerves*".

IV. Factors behind young people's decision to smoke

Several factors are related to smoking behaviour. Yet there is no relation strong enough for smoking behaviour to be understood on the basis of these factors alone. Most likely this behaviour is the result of a complicated interaction between these various factors.

A look at the factors behind the decision to try smoking (have already smoked, even if only once) shows that the strongest motivating force is the fact that the best friend smokes. Age comes only in second place, followed by a leisure factor (going to discotheques or dances), smoking by other members of the family, and the view that smoking has a favourable effect on relations with others (difficult to refuse the offer of a cigarette, pleasant atmosphere among workers).

Analysis of the factors that determine current behaviour (non-smoker, occasional smoker, regular smoker) produces similar, if slightly different results. Once again the list is headed by a best friend who smokes, followed by the view that smoking has a favourable effect on relations with others, but also the view that it has favourable effects on the individual, such as keeping slim, soothing the nerves and helping a person to work better. As for the family, it is no longer the fact that parents smoke that seems to play an important role here, but whether or not the parents take a permissive attitude to smoking.

In both these cases – starting to smoke and current behaviour – it seems that views on the dangers of tobacco, although widely held, play a very limited role.

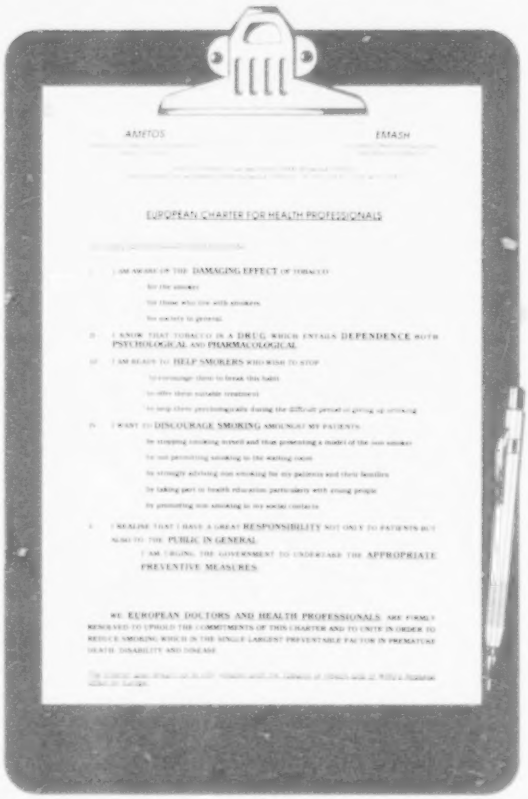
What about advertising? Its "*direct*" role – as measured here – is far from negligible in several countries, as regards both starting to smoke (Belgium, Germany, Portugal, Spain) and current smoking behaviour (France, Germany, Spain).

However, it is important to understand that advertising does not only, or even essentially, influence people directly. Rather it aims at building up a pleasant, positive image for the cigarette. To make someone always buy a certain brand – and thus instil a habit and create a dependence – you have to "*manipulate the imagination*".

HEALTH PERSONNEL

TOBACCO CONTROL: EMASH IN THE FOREFRONT!

The European Medical Association Smoking or Health (EMASH) is very active in smoking control and especially in building up awareness in the medical community. Noticing that doctors and other health professionals were rarely aware of their important role in the anti-smoking campaign, this French-based but Europe-oriented association established in 1988 has taken on the task of encouraging all health professionals, whether doctors or not, to assume their responsibility as opinion leaders and to set an example for the public regarding tobacco control.


AMETOS EMASH

EUROPEAN CHARTER FOR HEALTH PROFESSIONALS

I AM AWARE OF THE DAMAGING EFFECT OF TOBACCO
for the smoker
for those who live with smokers
for society in general

I KNOW THAT TOBACCO IS A DRUG WHICH ENTAILS DEPENDENCE BOTH PSYCHOLOGICAL AND PHARMACOLOGICAL

I AM READY TO HELP SMOKERS WHO WISH TO STOP
to encourage them to break this habit
to offer them suitable treatment
to help them psychologically during the difficult period of giving up smoking

I WANT TO DISCOURAGE SMOKING AMONGST MY PATIENTS
by stopping smoking myself and thus presenting a model of the non-smoker
by not permitting smoking in the waiting room
by strongly advising non-smoking for my patients and their families
by taking part in health education, particularly with young people
by promoting non-smoking in my social contacts

I REALISE THAT I HAVE A GREAT RESPONSIBILITY NOT ONLY TO PATIENTS BUT ALSO TO THE PUBLIC IN GENERAL
I AM URGING THE GOVERNMENT TO UNDERTAKE THE APPROPRIATE PREVENTIVE MEASURES

WE EUROPEAN DOCTORS AND HEALTH PROFESSIONALS ARE FIRMLY RESOLVED TO UPHOLD THE COMMITMENTS OF THIS CHARTER AND TO UNITE IN ORDER TO REDUCE SMOKING WHICH IS THE SINGLE LARGEST PREVENTABLE FACTOR IN PREMATURE DEATH, DISABILITY AND DISEASE

According to EMASH, health professionals are rarely aware of their role in tobacco control, and are sometimes blatantly indifferent to it. Only the non-smokers and ex-smokers among them feel concerned about the problem. Health professionals who smoke, like the general public, usually do not care.

It is high time, however, for doctors to become more concerned with the problem of smoking, even if that means questioning their own behaviour. As Europe moves towards unification, the tobacco control situation varies widely from one country to the next. A few countries are well advanced and have already acquired much experience and achieved good results. Others are still indifferent to the tobacco problem and allow themselves to be overrun by cigarettes. Still others, indeed the majority, have according to EMASH only taken half-measures to deal with the problem.

In all these countries, doctors and other health professionals have very different attitudes and knowledge concerning the problem. The Association aims to get them to meet in order to promote discussion and exchanges of opinion that will bring about change. EMASH is already represented in 25 European countries. In several of them, committees disseminate information and carry out research on specific experiments, from which they hope other countries will benefit. The goal is to be able to coordinate studies through a European network of national committees.

One of the first real achievements of EMASH is the **European Charter for Health Professionals,** drawn up in collaboration with the Tobacco or Health programme of the WHO Regional Office for Europe. In subscribing to it, doctors and health professionals commit themselves to join in the effort to *"reduce smoking, which is the single largest preventable factor in premature death, disability and disease"*.

If you are interested, please contact EMASH at:

European Medical Association Smoking or Health (AMETOS (Association Médicale Européenne Tabac ou Santé)),
26 rue Millière, 33000 Bordeaux, France.
Tel.: 56.91.64.01, - Fax: 56.91.79.83.

NEWS BRIEF

A COSTLY CIGARETTE BUTT ...

We are, alas, reminded all too often by the many forest fires caused by careless smokers who indiscriminately toss away their cigarette butts that it is not just our health that is endangered by tobacco smoking. Recently, there was another spectacular example of this when the computer room of a shipping company near Zurich airport in Switzerland was consumed by fire. A databank worth several hundred thousand Swiss francs was completely destroyed. The cause of the fire was a poorly extinguished cigarette that an absent-minded employee tossed into a cardboard box filled with old papers. This little news item gives new meaning to the slogan chosen for World No-Tobacco Day on 31 May 1992: *"Tobacco-free workplaces: safer and healthier"* ... and definitely less costly!

EPIDEMIOLOGY

TOBACCO USE IN BOMBAY

Tobacco-related diseases are becoming an increasingly important public health problem in India. There is an urgent need to control tobacco use.

With a view to establishing baseline prevalence, before undertaking a control programme, a survey in adult males (21 + years) was conducted in 4 of the 15 administrative units (wards) of Bombay, covering 30% of the population. A simple random sample of about 5 000 males was taken using electoral rolls as the sampling frame. A total of 2 305 males were interviewed for their demographic characteristics and tobacco habit.

Prevalence of tobacco chewers in adult males was significantly different in the 4 wards (the proportion varying from 17% to 28%) but not that of smokers (27%) or smoker-chewers (16%). No significant difference between age groups was observed for any of the habits.

Extrapolating from these proportions, it was estimated that 1.0 to 1.4 million adult males of Bombay (1986 population) chewed tobacco (irrespective of smoking), 1.3 million smoked (irrespective of chewing), and 0.5 million smoked as well as chewed. Thus there were 1.8 to 2.2 million tobacco users (i.e. 60 to 70% of adult males) in the city.

These estimates were remarkably similar to a second set of estimates based on prevalence in language groups. Furthermore, the estimated numbers of bidi and cigarette smokers were 0.6 million and 0.7 million, respectively.

The median frequency of tobacco chewing, bidi smoking and cigarette smoking was 5 times/day, 11/day to 22/day, and 7/day, respectively (in the four wards). The mean age at the start of each of the habits was 20 years approximately.

It was found that most (80%) of those interviewed were aware of the hazards of tobacco use. However, this awareness had not been translated into behavioural modification. It appears that educational programmes in Bombay have to focus on this aspect to achieve tobacco control in the population.

ESTIMATES FOR THOSE WHO USED TOBACCO REGULARLY IN BOMBAY (1986)

(Age group above 21 years)

Type of habit	Proportion in sample	Estimated number (million)
Tobacco chewers (TC)	17-28%*	0.5 - 0.9
Smokers (S)	27%	0.8
Smoker-chewer (SC)	16%	0.5
All tobacco users (ATU)	60-71%*	1.8 - 2.2
All tobacco chewers (TC + SC)	33-44%*	1.0 - 1.4
All smokers (S + SC)	43%	1.3
Bidi smokers only	19%	0.6
Cigarette smokers only	24%	0.7

* *Range of proportion in different administrative units.*

LEGISLATION

ANDORRAN HEAD OF GOVERNMENT ISSUES POWERFUL DECREE AGAINST TOBACCO CONSUMPTION AND SALE

"Es declara el tabac i el seus derivats com una substància nociva per a la salut de les persones. En conseqüència, en cas de conflicte prevaldrà sempre el dret a la salut dels no-fumadors sobre el dret dels fumadors a consumir manufactures del tabac als llocs i en les circumstàncies que preveu el present Decret."

This powerful formulation of anti-tobacco policy appears in a new Decree, which has just been promulgated by the Head of the Government of the Co-Principality of Andorra, with its population of just over 50 000. The Decree bans the sale and consumption of tobacco in various public and semi-public buildings and facilities. The provision quoted above declares tobacco and its derivatives to be substances that are harmful to human health. More boldly, it proclaims that, in the event of a conflict, *"the right to health of non-smokers shall always prevail over the right of smokers to consume tobacco products in premises or in the circumstances prescribed by the Decree"*.

Other significant legislative developments

In Germany, a new Tobacco Ordinance (dated 29 October 1991) requires the following warnings to appear on cigarette packages:

(1) "Smoking causes cancer";

(2) "Smoking causes heart and vascular diseases";

(3) "Smoking endangers your child's health, even during pregnancy";

(4) "If you give up smoking, you reduce the risk of serious disease".

Each of these warnings must be preceded by the words *"the European Community Health Ministers"*.

IARC NEWS

THE NEED FOR STUDIES ON TOBACCO USE AND RELATED MORBIDITY AND MORTALITY IN THE DEVELOPING WORLD

Global tobacco-related mortality is estimated at 3 million per year and a detailed computation of all smoking-attributable mortality for the United States has recently been produced. Tobacco-related cancer incidence and mortality have yet to be calculated precisely on a global scale. To do this it is useful to have accurate data on cancer mortality and incidence, and on tobacco use in all its forms, as well as an estimation of the precise relation between tobacco use and disease **for each country.**

The availability of such data varies greatly. Detailed mortality statistics, including cause of death, are available for the developed world, but the coverage for cancer mortality for the developing world is only 16%. It is particularly low in Asia (excluding Japan) and Africa, where cancer mortality statistics by specific cancers are, of course, even worse for incidence. While it was estimated that mortality data were available for 35-40% of the world population, the proportion for incidence is only 14%, corresponding to 58% for developed countries and only 2.3% for less developed ones.

An additional difficulty is that the population covered by cancer registries is often not representative of the country as a whole. In some countries, registries do not exist in big cities with multiple sources of medical care and therefore tend to include a rather rural population. In other countries, the opposite is true, with major cities being over-represented. Bombay, for example, has a registry dating back to 1963, which covers a very large population of about nine million people for Greater Bombay. In the absence of exhaustive coverage by cancer registries, some estimates have been made. The total number of all incident cases was estimated for 1980 at about 6.35 million, 3.25 for men and 3.10 for women. For men, lung cancer comes first, with 514 000 new cases or approximately 16% of all new lung cancer cases. For women, lung cancer occupies fifth position. Yet lung cancer is not the only cancer linked to tobacco use, and in countries such as India it would be a misleading indicator; there, cancer of the buccal cavity should be used instead, as tobacco chewing is most prevalent in the Indian sub-continent.

When adding up the proportion of cancers of the oral cavity, oesophagus, pancreas, larynx, lung, cervix, bladder and kidney, linked to smoking, it is estimated that between 1 and 1.5 million cancers per year are induced by tobacco use in the world. In order to obtain more precise estimates, carefully planned and conducted epidemiological studies are necessary.

One such project has started in Bombay, where the possibility of conducting a prospective cohort study of 100 000 men aged 35 and over chosen from the lists of voters in Bombay is being exploited. Providing the results of the feasibility study are acceptable, a five to ten-year follow-up study will be started to assess the cause-specific mortality of the cohort, with particular attention being given to cancer and other causes of death in relation to the various forms of tobacco use (smoking, chewing, snuff, etc.). Similar studies, as well as case-control studies where appropriate, would provide much needed information, for example in Africa, South America and other parts of Asia.

WHO/TOH PROGRAMME

WHO'S IN CHARGE IN WHO?

At WHO headquarters the TOH programme has been strengthened by the arrival of Mr Neil Collishaw who joined the programme in November 1991. Mr Collishaw, who holds a Master's degree in sociology, comes from the Canadian Department of National Health and Welfare and has over two decades of experience in public health work. For the last ten years he has worked full-time on tobacco control issues in Canada, including assisting in the implementation and management of Canada's excellent comprehensive national tobacco control programmes. During his time with TOH, he will work more specifically on the development of national tobacco control programmes.

In addition, the TOH programme has received the support of the Norwegian government which is financing an associate professional officer, Pål Kraft, MA, DDS, Ph.D., for a period of two years. Dr Kraft, who joined the programme in October 1991, has worked with the Department of Health Education, National Health Screening Service of Norway, and with the Department of Epidemiology, National Institute of Public Health, Norway. He has experience in health education at the national level and research experience in the fields of health education and health behaviour. It is hoped that his work will strengthen all areas of the TOH programme.

Roberto Masironi, Ph.D., who was a member of the staff of the TOH programme since its creation, retired in September 1991.

This newsletter is issued by the WHO programme on Tobacco or Health (TOH), World Health Organization, 1211 Geneva 27, Switzerland. The text may be freely reproduced and illustrations may be used, giving credit to WHO. Cuttings are requested. Contributions and suggestions to be addressed to Dr C. Chollat-Traquet, Editor.

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